Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS649HOS	A. BUILDING _____ B. WING _____	04/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH VISTA HOSPITAL	1409 EAST LAKE MEAD BLVD NORTH LAS VEGAS, NV 89030

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S 000	Initial Comments This Statement of Deficiencies was generated as the result of a state licensure complaint investigation survey initiated at your facility on April 24, 2009 and finalized on April 28, 2009. The survey was conducted using the authority of NAC 449, Hospitals, last adopted by the State Board of Health on August 04, 2004. The following complaints were investigated. Complaint #NV00018868 - Unsubstantiated Complaint #NV00019860 - Unsubstantiated Complaint #NV00020734 - Unsubstantiated Complaint #NV00019298 - Substantiated without deficiencies. Complaint #NV00021580 - Substantiated (Tag # S0153, S0295, S0300, S0311, S0322) The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. The following regulatory deficiencies were identified.	S 000		
S 153 SS=D	NAC 449.332 Discharge Planning 11. The patient, members of the family of the patient and any other person involved in caring for the patient must be provided with such information as is necessary to prepare them for the post-hospital care of the patient.	S 153		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S 153	Continued From page 1 This Regulation is not met as evidenced by: Based on interview, record review and document review the facility failed to ensure family members involved in the patients care were notified the patients discharge/transfer to a rehabilitation center was canceled. (Patient #5) Findings include: The Physician's History and Physical dated 12/02/08 indicated Patient #5 was a 77 year old male who became increasingly aggressive towards his wife at home. The patient had thought disorganization and confusion coincident to delusions and paranoid ideations. There was also some physical aggression by the patient toward his wife. The patient was admitted to the Gero Psych unit for further evaluation and treatment. The patients diagnoses included organic delusional disorder, organic affective disorder, diabetes and bipolar disorder. A family member indicated on 12/13/08, the facility called and notified the family member that the patient was being transferred to a rehabilitation center in the evening. The family member reported she went to the rehabilitation center and discovered the patient was not there. The family member went to the facility and discovered the patient had been transferred to a medical unit and placed in isolation due to an infected right leg. The family member reported the nursing staff and case manager did not notify her of the canceled transfer of Patient #5. On 04/28/09 at 11:00 AM, the Chief Nurse acknowledged the facility and case manager should have notified the family that the patients transfer to the rehabilitation center was canceled due to a medical complication.	S 153		

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S 153	Continued From page 2 A Physician Order dated 12/12/08 at 9:47 AM, included an order to transfer the patient to rehab if cleared by psychiatry and a case management consult for placement. A review of the medical records indicated the patient developed an infection in his right leg and and was diagnosed with sepsis on 12/13/08. A Physicians Order dated 12/13/08 indicated the patients transfer to a rehabilitation unit was canceled and the patient was transferred to a medical surgical floor at the facility. A wound care consult for right lower leg was ordered by the physician. There was no documented evidence in the medical record that indicated the family was called and notified by nursing staff or case management that the patients transfer to a rehabilitation center was canceled. The facility Discharge Instruction Policy last revised 04/08, included the following: Policy: "There will be an established mechanism to ensure that each patient being discharged from the facility receives appropriate discharge instructions to facilitate his transition to home and/or other facility." Procedure: "The Discharge Plan/Instructions will be reviewed with the patient, significant other and/or responsible party to ensure their understanding of the instructions."	S 153		

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S 153	Continued From page 3 The facility Discharge Planning-General Guidelines last revised 06/08 included the following: "Information from the health care team is essential to the patient and family, who will be selecting post hospital care based on these factors combined with suitability and availability of local resources." "With the patients consent, basic medical, social and financial information is utilized in the referral process. Such information may contain activity of daily living goals and current function, physical therapy performance, physical status,etc. If for any reason the plan is altered or abandoned this will also be documented in the medical record." Severity: 2 Scope: 1 Complaint # 21580	S 153		
S 295 SS=D	NAC 449.361 Nursing Services 6. A hospital shall ensure that the nursing staff develops and keeps current a plan for nursing care for each inpatient. This Regulation is not met as evidenced by: Based on interview, record review and document review the facility failed to ensure the nursing staff developed and kept current a nursing care plan for a patient. (Patient #5) Findings include: 1. The Physician's History and Physical dated	S 295		

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S 295	Continued From page 4 12/02/08 indicated Patient #5 was a 77 year old male who became increasingly aggressive towards his wife at home. The patient had thought disorganization and confusion coincident to delusions and paranoid ideations. There was also some physical aggression by the patient toward his wife. The patient was admitted to the Gero Psych unit for further evaluation and treatment. The patients diagnoses included organic delusional disorder, organic affective disorder, diabetes and bipolar disorder. A review of the nursing notes indicated the nurses on the Gero Psych unit identified an abnormality with the skin on the patients right leg on 12/09/08 and the patients left coccyx region on 12/10/08. The patients right leg became red, swollen and a cellulitis developed. The patient developed a right leg wound described as edematous with necrotic wound and redness surrounding the area. The patient developed a stage 2 (partial thickness skin loss involving epidermis and or dermis, not penetrating through dermis) decubitus coccyx ulcer. The physician progress notes and nursing notes revealed the physician was not notified by the nurses about the patient's right leg cellulitis and wound until 12/13/08. The patient was then diagnosed with sepsis and transferred to a medical surgical unit. On 04/28/09 at 9:00 AM, the Chief Nurse reviewed Patient #5's physician progress notes, nursing notes and nursing care plan and acknowledged the facility nurses failed to follow hospital policy and notify the physician when there was a change in the patients condition. The Chief Nurse confirmed the facility nurses failed to notify the physician when the patients right leg wound and coccyx wound were first identified and	S 295		

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S 295	Continued From page 5 when both wounds intensified in severity. The Chief Nurse acknowledged the facility nurses failed to document the patients potential for skin breakdown and the patients skin wounds once they developed on the nursing care plan. The Chief Nurse acknowledged the nurses did not follow facility policy and document the goals, objectives or clinical interventions for the patients skin breakdown on the nursing care plan. A review of the facility's Multidisciplinary Integrated Treatment Plan for Patient #5 dated 12/02/08, revealed no documentation of a potential for skin breakdown or any skin ulcers or wounds identified on the patients right leg or coccyx region. There was no documentation of goals, objectives or clinical interventions on the care plan for skin breakdown. The facility Pressure Ulcer, Skin Care Protocol last renewed 02/09, included under Procedures: "8. The licensed professional will develop a plan of care to prevent /or treat compromised skin integrity. Such plan of care will include but is not limited to: a. Notify the primary care physician of the skin breakdown and obtain wound care orders. b. Communicating with the facility skin care team representatives regarding care and treatment of wound." 2. A Nutritional Assessment Form dated 12/03/08 and filled out by a registered dietician indicated the recommendation included a CNA (certified nursing assistant) provide assistance to the patient with meals and encourage PO (by mouth) intake.	S 295		

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S 295	Continued From page 6 The facility's Multidisciplinary Integrated Treatment Plan for Patient #5 dated 12/02/08, indicated under Problem #2, appetite disturbance. There were no goals, objectives or clinical interventions documented on the patients nursing care plan for appetite disturbance. The Activities of Daily Living Flow Sheet for 12/05/08, revealed no documentation of percentage of food the patient consumed for lunch or dinner. The flow sheet for 12/07/08 revealed no percentage of food consumed for dinner. On 04/28/09 at 9:00 AM, the Chief Nurse acknowledged the nurses did not follow the facility policy and document the goals, objectives or clinical interventions for appetite disturbance on Patient #5's nursing care plan. Severity: 2 Scope: 1 Complaint # 21580	S 295		
S 300 SS=D	NAC 449.3622 Appropriate Care of Patient 1. Each patient must receive, and the hospital shall provide or arrange for, individualized care, treatment and rehabilitation based on the assessment of the patient that is appropriate to the needs of the patient and the severity of the disease, condition, impairment or disability from which the patient is suffering. This Regulation is not met as evidenced by: Based on interview, record review and document review the facility failed to ensure a patient received the appropriate individualized care,	S 300		

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S 300	Continued From page 7 treatment and rehabilitation based on the assessment of the patient. (Patient #5) Findings include; 1. The Physician's History and Physical dated 12/02/08, indicated Patient #5 was a 77 year old male who became increasingly aggressive towards his wife at home. The patient had thought disorganization and confusion coincident to delusions and paranoid ideations. There was also some physical aggression by the patient toward his wife. The patient was admitted to the Gero Psych unit for further evaluation and treatment. The patients diagnosis included organic delusional disorder, organic affective disorder, diabetes and bipolar disorder. A review of the nursing notes indicated the nurses on the Gero Psych unit identified an abnormality with the skin on the patients right leg on 12/09/08 and the patients left coccyx region on 12/10/08. The patient's right leg became red, swollen and a cellulitis developed. The patient developed a right leg wound described as edematous with necrotic wound and redness surrounding the area. The patient developed a stage 2 (partial thickness skin loss involving epidermis and or dermis, not penetrating through dermis) decubitus coccyx ulcer. The physician progress notes and nursing notes revealed the physician was not notified by the nurses about the patients right leg cellulitis and wound until 12/13/08. The patient was then diagnosed with sepsis and transferred to a medical surgical unit. On 04/28/09 at 9:00 AM, the Chief Nurse reviewed Patient #5's physician progress notes,	S 300		

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S 300	Continued From page 8 nursing notes and nursing care plan and acknowledged the facility nurses failed to follow hospital policy and notify the physician when there was a change in the patients condition. The Chief Nurse confirmed the facility nurses failed to notify the physician when the patient's right leg wound and coccyx wound were first identified and when both wounds intensified in severity. The Chief Nurse acknowledged the facility nurses failed to document the patient's potential for skin breakdown and the patients skin wounds once they developed on the nursing care plan. The Chief Nurse acknowledged the nurses did not follow facility policy and document the goals, objectives or clinical interventions for the patients skin breakdown on the nursing care plan. A review of the facility's Multidisciplinary Integrated Treatment Plan for Patient #5 dated 12/02/08, revealed no documentation of a potential for skin breakdown or any skin ulcers or wounds identified on the patients right leg or coccyx region. There was no documentation of goals, objectives or clinical interventions on the care plan for skin breakdown. The facility Pressure Ulcer, Skin Care Protocol last renewed 02/09, included under Procedures: "8. The licensed professional will develop a plan of care to prevent /or treat compromised skin integrity. Such plan of care will include but is not limited to: a. Notify the primary care physician of the skin breakdown and obtain wound care orders. b. Communicating with the facility skin care team representatives regarding care and treatment of wound."	S 300		

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S 300	Continued From page 9 2. A Nutritional Assessment Form dated 12/03/08 and filled out by a registered dietician indicated the recommendation included a CNA (certified nursing assistant) provide assistance to the patient with meals and encourage PO (by mouth) intake. The facility's Multidisciplinary Integrated Treatment Plan for Patient #5 dated 12/02/08, indicated under Problem #2, appetite disturbance. There were no goals, objectives or clinical interventions documented on the patients nursing care plan for appetite disturbance. The Activities of Daily Living Flow Sheet for 12/05/08, revealed no documentation of percentage of food the patient consumed for lunch or dinner. The flow sheet for 12/07/08, revealed no percentage of food consumed for dinner. On 04/28/09 at 9:00 AM, the The Chief Nurse acknowledged the nurses did not follow facility policy and document the goals, objectives or clinical interventions for appetite disturbance on Patient #5's nursing care plan. Severity: 2 Scope: 1 Complaint # 21580	S 300		
S 311 SS=D	NAC 449.3624 Assessment of Patients 2. Each patient must be reassessed according to hospital policy: (a) When there is a significant change in his condition	S 311		

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S 311	Continued From page 10 This Regulation is not met as evidenced by: Based on interview, record review and document review the facility failed to follow its policies and procedures and notify a physician when there was a significant change in a patients condition. (Patient #5) Findings include: The Physician's History and Physical dated 12/02/08 indicated Patient #5 was a 77 year old male who became increasingly aggressive towards his wife at home. The patient had thought disorganization and confusion coincident to delusions and paranoid ideations. There was also some physical aggression by the patient toward his wife. The patient was admitted to the Gero Psych unit for further evaluation and treatment. The patients diagnosis included organic delusional disorder, organic affective disorder, diabetes and bipolar disorder. A review of the nursing notes indicated the nurses on the Gero Psych unit identified an abnormality with the skin on the patients right leg on 12/09/08 and the patients left coccyx region on 12/10/08. The patients right leg became red, swollen and a cellulitis developed. The patient developed a right leg wound described as edematous with necrotic wound and redness surrounding the area. The patient developed a stage 2 (partial thickness skin loss involving epidermis and or dermis, not penetrating through dermis) decubitus coccyx ulcer. The physician progress notes and nursing notes revealed the physician was not notified by the nurses about the patients right leg cellulitis and wound until 12/13/08. The patient was then diagnosed with sepsis and transferred to a medical surgical unit.	S 311		

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S 311	Continued From page 11 On 04/28/09 at 9:00 AM, the Chief Nurse reviewed Patient #5's physician progress notes, nursing notes and nursing care plan and acknowledged the facility nurses failed to follow hospital policy and notify the physician when there was a change in the patients condition. The Chief Nurse confirmed the facility nurses failed to notify the physician when the patients right leg wound and coccyx wound were first identified and when both wounds intensified in severity. The Chief Nurse acknowledged the facility nurses failed to document the patients potential for skin breakdown and the patients skin wounds once they developed on the nursing care plan. A review of the facility's Multidisciplinary Integrated Treatment Plan for Patient #5 dated 12/02/08, revealed no documentation of a potential for skin breakdown or any skin ulcers or wounds identified on the patients right leg or coccyx region. There was no documentation of goals, objectives or clinical interventions on the care plan for skin breakdown. The facility Pressure Ulcer , Skin Care Protocol last renewed 02/09, included under Procedures: "8. The licensed professional will develop a plan of care to prevent /or treat compromised skin integrity. Such plan of care will include but is not limited to: a. Notify the primary care physician of the skin breakdown and obtain wound care orders. b. Communicating with the facility skin care team representatives regarding care and treatment of wound." Severity: 2 Scope: 1	S 311		

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S 311	Continued From page 12 Complaint # 21580	S 311		
S 322 SS=D	NAC 449.3628 Protection of Patients 2. The governing body shall develop and carry out policies and procedures that prevent and prohibit neglect and misappropriation of the personal property of a patient. This Regulation is not met as evidenced by: Based on record review and document review the facility failed to carry out policies and procedures to prevent neglect of the personal property of a patient. (Patient #5) Findings include: Patient #5 was admitted to the hospital on 12/2/08. A family member indicated when Patient #5 was admitted to the hospital he had upper and lower dentures in his mouth. The family member was informed by the nurses the patient was not eating. The family member reported on two occasions while visiting the patient she found the patient restrained in a restraint chair and his food tray left for him. The patient could not reach the tray to feed himself. The family member indicated when she started to feed the patient she discovered his lower denture plate was missing. The family member reported the missing denture plate to the facility who informed her the patients lower denture plate had been lost. The Patient Valuable and Belongings Form from the Gero Psych unit dated 12/02/08, documented	S 322		

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S 322	Continued From page 13 under dentures/partial/upper/lower no entry was made. The facility incident report dated 12/19/08 at 2:39 PM, indicated the following: "Gero Psych staff stated the patient was not brought in with dentures, although patient had upper dentures in place. Emergency room staff contacted and no dentures located." The facility Valuables and Belongings Policy last revised 10/08, documented the following: "All personal items including valuables will be identified and accounted for on a patients cloths and valuables list by nursing personnel. Eye glasses, hearing aids, dentures are usually considered to be patient's belongings. If the patient was admitted from the emergency department and transferred to ICU (intensive care unit), T2, or T3, the receiving nurse will verify the patients belongings/valuables and sign off on the document validating all belongings/valuables were accounted for upon transfer. If a patient was being admitted to or from the Gero Psych Unit, a new patient valuables and belongings form must be initiated." A review of the patients belongings form indicated the facility failed to accurately document the patients upper and lower dentures when he was transferred from the emergency room to the Gero Psych unit. Severity: 2 Scope: 1 Complaint # 21580	S 322		